STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 00 B. WING	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF JEFFERSON POINTE	5700 WILKIE DR FORT WAYNE, IN 46804

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00426642, IN00426663, IN00426877, IN00426890, and IN00427824. Complaint IN00426642 - No deficiencies related to the allegations are cited. Complaint IN00426663 - Federal/state deficiencies related to the allegations are cited at F760. Complaint IN00426877 - Federal/state deficiencies related to the allegations are cited at F760. Complaint IN00426890- Federal/state deficiencies related to the allegations are cited at F600. Complaint IN00427824- No deficiencies related to the allegations are cited. Survey dates: Feburary 13 and 14, 2024. Facility number: 000476 Provider number: 155446 AIM number: 100290870 Census Bed Type: SNF/NF: 95 Total: 95 Census Payor Type: Medicare: 4 Medicaid: 69 Other: 22 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Holbrook	Executive Director	02/28/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed February 20, 2024			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on interview and record review the facility failed to ensure residents were free from verbal abuse for 1 of 6 residents reviewed (Resident F). Findings include: A facility reported incident was provided by the Administrator on 2/13/24 at 1 PM. The report indicated Resident F had reported to the staff about an incident with Licensed Practical Nurse 3. The report indicated on 1/22/24, LPN 3 had made the comment "you mean, miserable man - people like you in my country, we cut their heads off." An investigation file was provided by the Administrator on 2/14/24 at 11:30 AM. The filed statements indicated the following: - Dated 1/23/24 by Resident F indicated on 1/22/24	F 0600	Majestic Care of Jefferson Pointe would like to respectfully request a desk review for the deficiency cited. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The facility is unable to correct the alleged deficient practice for the resident. Staff member was terminated. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken? All residents have the potential to be affected by the alleged deficient	02/28/2024

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	LPN 3 had assisted with setting up Resident F's breathing treatment and LPN 3 had knocked a few things off the resident's night stand. The statement indicated Resident F stated to LPN 3 "you just don't know what you are doing, do you? LPN 3 responded "Im African, people like you get their heads cut off in my country." - Dated 1/29/24 by LPN 3 indicated on 1/22/24 LPN 3 while setting up Resident F's breathing treatment, Resident F stated "'you just don't know what you are doing, do you?" The statement indicated Resident F then called LPN 3 a "stupid African." LPN 3 indicated he responded "I'm am trying to get along with you." LPN 3 indicated he stated "I'm African, people like you get their heads cut off in my country." During an interview on 2/14/24 at 11:30 AM, the Administrator indicated Resident F had reported an incident with LPN 3. Resident F indicated LPN 3 made inappropriate comments to the resident, such as "I'm African, people like you in my country, we chopped their heads off." The Administrator indicated he interviewed Resident F and LPN 3 and found the statements to be accurate. The Administator indicated LPN 3 was terminated. A policy, dated 2/2018, titled "Abuse prevention program," was provided by the Regional Consultant on 2/14/24 at 1:34 PM. The policy indicated "verbal abuse was the use of any oral, written or gestured language that willfully included disparaging and derogatory terms to the residents and/or families regardless of age, ability to comprehend or disability." This citation relates to Complaint IN00426890.		practice. All alert and oriented residents interviewed with no concerns noted. Skin assessments completed on all other residents. What measures will be put into place and what systemic changes will be made to ensure the deficient practice does not recur? All staff will be re-educated on the Abuse, Neglect, and Exploitation Policy. 5 Alert and oriented residents each week will be interviewed using the abuse questionnaire and 5 other residents will have skin assessments completed weekly X6 months. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Results of audits will be discussed at monthly Quality Assurance Meetings. If 100% threshold is not met, then an action plan will be developed. The QA committee will adjust audits based on the findings. Date of compliance: 2/29/24	

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F 0760 SS=G Bldg. 00	3.1-27(b) 483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on interview and record review the facility failed to ensure residents were free from significant medication errors for 2 of 4 residents reviewed for medication errors. The deficient practice resulted in Resident B experiencing altered mental status that required emergent treatment at the facility for opioid overdose and hospitalization for chest pain. The deficient practice resulted in Resident C experiencing altered mental status with lethargy that required hospitalization. (Resident B, Resident C). 1. An Indiana Department of Health (IDOH) facility-reported incident report was provided by the Administrator on 2/13/24 at 1:00 P.M. The report indicated Resident B had returned from the pain management clinic on 1/19/24 with a new medication order for Suboxone 2.0-0.5 milligram one tablet SL every eight hours for pain. The report indicated the Assistant Director of Nursing (ADON) entered the new order into the electronic medication administration record (EMAR). The report indicated the correct amount of tablets for administration had been inaccurately transcribed into the EMAR as "eight" and LPN 5 incorrectly administered eight tablets of the opioid medication on 1/19/24 at 9:00 P.M. and 1/20/24 at 5:00 A.M. The report indicated Resident B required a rescue dose of Narcan (an antagonist medication to reverse an opioid overdose) and emergent transfer to the hospital for treatment of altered mental status. The incident report indicated LPN 6 questioned the amount of tablets	F 0760	Past non-compliance approved.	02/29/2024

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	during medication preparation activities, on 1/20/24 at 1:00 P.M. and held the dose. Resident B's record was reviewed on 2/13/24 at 1:00 P.M. Diagnoses included congestive heart failure, end stage renal disease and chronic pain syndrome. A Quarterly MDS (Minimum Data Set) assessment dated 12/26/23, indicated Resident B had no cognitive impairment, was able to understand and able to make himself understood. A pain management visit note, dated 01/18/2024, indicated Resident B received a new medication order to refill Suboxone (brand name for buprenorphine/naloxone) (an opioid pain medication) 2.0-0.5 milligram (mg) one tablet sublingual (SL) every eight hours for pain. A nursing note, dated 1/20/24 at 1:00 P.M., indicated staff noted Resident B was lethargic and was unable to speak. The nurse indicated the resident had a medication order for Suboxone 8 tablets. The note indicated Narcan was administered three minutes apart. An order to send to the emergency room was obtained. The note also indicated Resident B had refused to go to the emergency room. A nursing note, dated 1/20/24 at 9:30 PM, indicated Resident B was very lethargic with garbled speech. The note indicated Narcan was given twice and the resident had clear speech after 15 minutes. The note indicated Resident B expressed chest pain and was sent to the hospital. The Medication Administration Record (MAR), dated 1/19/24 - 1/20/24 indicated Resident B received eight tablets of Suboxone on 1/19/24 at			

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	9:00 P.M. and 1/20/24 at 5:00 A.M. During an interview on 2/14/24 at 11:30 AM, the Administrator indicated Resident B had returned from the pain management doctor with a new prescription for Suboxone. The Administrator indicated the ADON (Assistant Director of Nursing) assisted nursing staff by entering the order into the resident's MAR, but the ADON entered the order incorrectly. The Administrator indicated the order from the pain management doctor was to administer 1 tablet of Suboxone 2-0.5 mg every 8 hours for pain, but the ADON incorrectly entered the amount of tablets as eight. The Administrator indicated the medication was inaccurately administered on 01/19/24 at 9:00 P.M. and 01/20/24 at 5:00 A.M. and LPN 6 identified the error on 01/20/24 at 1:00 P.M. The Administrator indicated Resident B was sent to the emergency room. According to drugs.com, in the event of overdose, the respiratory and cardiac status of the patient should be monitored carefully. When respiratory or cardiac functions are depressed, primary attention should be given to the re-establishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. Oxygen, IV fluids, vasopressors, and other supportive measures should be employed as indicated. 2. In a confidential interview on 2/13/24 at 1:45 P.M., a family member indicated Resident C had received three times the ordered dosage of gabapentin (an anticonvulsant medication) and the wrong dosage of Depakote (divalproex sodium) (an anticonvulsant medication). The family indicated Resident C was in the hospital for			

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3 days.

Resident C's record was reviewed on 2/13/24 at 2 PM. Diagnoses included end stage renal disease, bipolar disorder, schizophrenia, behavioral disturbances, and seizures.

A nursing note, dated 1/11/24, entered by LPN 3, indicated a new order was received for gabapentin 300 mg TID (three times a day) and Depakote 500mg BID (two times a day) for behavioral disturbances, seizures, and bipolar disorder.

An untimed neurology physician's order, dated 1/11/24, indicated Resident C should receive gabapentin 300 mg one capsule at hs (bedtime). (total 300 mg daily)

The January 2024 MAR indicated Resident C received gabapentin 300 mg as follows:
01/12/24- 9:00 AM, 1:00 P.M., and 5:00 P.M.
01/13/24- 9:00 AM, 1:00 P.M., and 5:00 P.M.
01/14/24- 9:00 AM, 1:00 P.M., and 5:00 P.M.

An untimed neurology physician's order, dated 1/11/24, indicated Resident C should receive Depakote ER (extended release) 500 mg two tablets twice daily. (total 2,000 mg daily)

The January 2024 MAR indicated Resident C received Depakote 500 mg one tablet as follows:
01/12/24- 7:00 A.M. and 6:00 P.M.
01/13/24- 7:00 A.M. and 6:00 P.M.
01/14/24- 7:00 A.M. and 6:00 P.M.
The MAR indicated Resident C received 1000 mg of the anticonvulsant medication daily for three days.

A nursing note, dated 1/15/24, indicated Resident C had an altered mental status, was lethargic, and

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	was sent to the hospital. During an interview on 2/14/24 at 1:09 P.M., LPN 2 indicated when a new order was received from the physician, he would verify the order and enter the data into the computer. LPN 2 indicated if he didn't have time the unit manager entered orders. LPN 2 indicated when while entering and/or administering medication he would verify the order with the Nurse Practitioner if anything seemed odd. During an interview on 2/14/24 at 1:14 P.M., Qualified Medication Aide (QMA) 4 indicated new orders were entered into the patient's chart by the nurse or unit manager. QMA 4 indicated it is her usual practice to doublecheck an order with the nurse, unit manager, or MDS Coordinator when she has questions while preparing medication for administration. QMA 4 also indicated nurses are not to enter orders of medication changes without permission from the nurse practitioner and/or prescribing doctor. According to Mayoclinic.org, Depakote levels need to be kept within therapeutic levels to prevent seizure activity. The website indicated the medication should be taken exactly as ordered. Taking inadequate dosages of the medication Depakote could result in intractable seizures (seizures that cannot be stopped easily). According to Drugs.com, Gabapentin side effects may result in dizziness, sleepinesss, and weakness. If overdose is suspected, poison control should be called right away and medical care should be started immediately. The website indicated to be ready to tell or show what was taken, how much and when it happened.			

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	A policy, dated 10/2023, titled "Medication Errors," was provided by the Regional Consultant on 2/14/24 at 1:34 PM. The policy indicated medications are administrated per the physician's orders. The policy also indicated when dosage orders were written and not within the usual dosages/frequency range, the nurse was to clarify the orders with the physician and/or NP. The facility corrected the deficient practice prior to the beginning of the current survey, on 2/1/2024, after completing review of all orders of residents who received orders from the pain management clinic, progress notes, educating staff on questioning orders outside of dosage/ frequency range, and monitoring new orders daily x 4 weeks, then every weekday x 5 months. This citation relates to Complaints IN00426663 and IN00426877. 3.1-48(c)(2)			